State of Franklin Healthcare Associates

Patient Information

Patient Full Name: _____ **Date of Birth:** _____

Preferred Name ***(If different than above)*****:** _____

Social Security Number: _____ **Email:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell #: ☐ _____ **Home #:** ☐ _____ **(check box of primary phone)**

Place of Employment: _____ **Work #:** _____

Sex: ☐ Male ☐ Female ☐ Unknown

Please select your preferred language:

☐ English ☐ Spanish ☐ Chinese ☐ French ☐ Other (identify below)
_____

Please select your race:

☐ American Indian or Alaskan Native
☐ Black or African American
☐ Unreported/Refused to Report
☐ Asian
☐ White
☐ Biracial/Multiracial
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Unknown

Please select your ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Unreported/Refused to Report

Marital Status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed ☐ Life Partner

Primary Insurance: _____ **Insurance ID:** _____

Policy Holder Name: _____ **Date of Birth:** _____

Relationship To Patient: _____

Secondary Insurance: _____ **Insurance ID:** _____

Policy Holder Name: _____ **Date of Birth:** _____

Relationship To Patient. _____

Patient Medical History

Patient Full Name: _____ Date of Birth: _____

Date of Last Physical Exam: _____ Doctor: _____

Current / Past Medical History

Check below to report if you have or ever been treated for the following medical conditions.
(Circle to indicate Past or Present)

☐ **Addiction**	Present	☐ **Diabetes**	Present	☐ **Lung Problems**	Present
☐ **Arthritis**	Present	☐ **Heart Problems**	Present	☐ **Neurological Problems**	Present
☐ **Blood Condition**	Present	☐ **High Blood Pressure**	Present	☐ **Osteoporosis**	Present
☐ **Cancer**	Present	☐ **High Cholesterol**	Present	☐ **STD**	Present
☐ **Depression/Anxiety**	Present	☐ **Irritable Bowel**	Present	☐ **Thyroid Problems**	Present

Please list any additional medical conditions:

_____
_____
_____
_____

Allergies: *Please check allergies you have and list your reaction*

☐ **Sulfa -drugs**	☐ **Codeine**	☐ **Eggs**	☐ **Gluten**	☐ **Dairy**
☐ **Penicillin**	☐ **Latex**	☐ **Nuts**	☐ **Fish**	☐ **Shellfish**

☐ **Other** _____

Reaction to above: _____

Family Medical History

☐ **Adopted or Unknown/Incomplete Family History**

	If Living, Age?	If Deceased, age at death?	Cause of death if known?
Mother			
Father			
Brother			
Sister			
Daughter			
Son			
Husband			
Wife			

Check all that apply below related to family medical history. *(Please list the age when they had the problem if you know it)*

	Mother	Father	Sister	Brother	Daughter	Son
Addiction						
Arthritis						
Asthma						
Blood Conditions						
Cancer						
Colitis						
Diabetes						
Epilepsy						
Goiter *(Thyroid Conditions)*						
Hay Fever						
Heart Conditions						
High Blood Pressure						
Kidney Disease						
Leukemia						
Liver Disease						
Mental Health Disorders						
Migraine						
Stomach Ulcers						
Stroke						
Tuberculosis						
Other (List)						

Social History

Smoke Cigarettes? ☐ **Yes** ☐ **No** ***Current*: Packs/day _____. # of Years _____**

***Past*: Quit Date _____ Packs/Day _____ # of Years _____**

Other Tobacco *(check one)*: ☐ **Pipe** ☐ **Cigar** ☐ **Snuff** ☐ **Chew**

Use Caffeine? ☐ **Yes** ☐ **No If YES,** ☐ **Coffee** ☐ **Tea** ☐ **Soda** ☐ **Other _____ # of cups per day _____**

Do you regularly drink alcohol? ☐ **Yes** ☐ **No Specify:** ☐ **Beer** ☐ **Wine** ☐ **Liquor # of Drinks/Week: _____**

Do you have difficulty falling asleep? ☐ **Yes** ☐ **No**

Do you awaken early in the morning without apparent cause? ☐ **Yes** ☐ **No**

Have you ever lived outside of the U.S. and Canada? ☐ **Yes** ☐ **No**

Medications

Pharmacy: _____ Location: _____ Ph # _____

Please list ALL medications, strength, and dosage. Include Inhalers, Vitamins, Supplements, and Over the Counter Medications. If you are unsure, please bring your bottles with you to your appointment.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Female History to be answered by WOMEN ONLY

Are you still having regular monthly menstrual periods? ☐ **Yes** ☐ **No** If YES, date of last menstrual period? _____

Have you ever had bleeding between your periods? ☐ **Yes** ☐ **No** If yes, frequency and when? _____

Do you ever have very heavy bleeding with your periods? ☐ **Yes** ☐ **No**

Do you feel bloated and irritable before your period? ☐ **Yes** ☐ **No**

Are you now or have you ever taken birth control? ☐ **Yes** ☐ **No** If YES, when and name of birth control:

_____

Have you ever been pregnant? ☐ **Yes** ☐ **No** If YES, how many births? _____

Any cesarean operations? ☐ **Yes** ☐ **No**

Have you ever had a miscarriage or abortion? ☐ **Yes** ☐ **No** If YES, when? _____

Surgical History

Please list below surgeries you have had including the year it was performed.

Procedure - Year	**Procedure - Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Preventive Health Maintenance

Check below to report you have completed any of the following preventive health maintenance screenings.
(List date and location if known)

Screening	Date	Location
☐ Colonoscopy		
☐ Diabetic Eye Exam		
☐ Diabetic Foot Exam		
Patients With History of Smoking		
☐ AAA Screen *(Men ages 65-75)*		
☐ LDCT (Lung Cancer Screen)		
Female Patients		
☐ DEXA *(Bone Density)*		
☐ Mammography		
☐ Pap Smear Screening		

Immunizations

Please check immunizations you have and year if known.

☐ **Tdap_____** ☐ **Shingles _____** ☐ **Pneumonia _____** ☐ **COVID _____** ☐ **Hep B _____**

☐ **Flu _____** ☐ **HPV (For ages greater than 26 years _____**

☐ **Other: _____**

Please list providers you currently see for any of the following below

Specialty	Name of Provider	Location and Phone Number
Cardiovascular *(Heart)*		
Dermatology *(Skin)*		
Gastroenterology *(Colon, Stomach)*		
Nephrology *(Kidney)*		
Neurology, Neurosurgery *(Brain/Spine)*		
OBGYN *(Women's Health)*		
Oncology *(Cancer)*		
Ophthalmology/Optometry *(Eyes)*		
Orthopedic *(Bones)*		
Podiatry *(Feet)*		
Pulmonology *(Lung)*		
Rheumatology *(Arthritis)*		
Urology *(Bladder)*		

Other Providers (Please List):

_____

_____

By completing and submitting this new patient, you are requesting medical care and treatment at this facility and agree to accept services which may diagnose a medical condition, procedure to treat medical conditions, and routine medical care, including vaccinations. I understand that these services will be provided to me by physicians, nurse practitioners, midwives, physician assistants, and other health care professionals, some of whom may be in training. I have not been given any guarantees as to the results of the services I will receive. I understand that my agreement to accept these services is considered General Consent and will remain in effect unless I say that I no longer want these services or until my treatment is completed.

Signature: _____ Date: _____

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